MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-037549 STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9203

FILED SEP 19 1963

DO NOT WRITE ON THIS STUB — AMENDED

VS 300 Rev. 4/59

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF DOCUMENT

ITEM NO. SHOULD READ BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jewish Hospital
Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY
c. CITY OR TOWN St. Louis
Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 212 N. Kingshighway
Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First LEO Middle C. Last FULLER
4. DATE OF DEATH Month September Day 13 Year 1963
5. SEX Male
6. COLOR OR RACE White
7. Married ☐ Never Married ☐ Widowed ☐ Divorced ☒
8. DATE OF BIRTH 8/23/89
9. AGE (last birthday) 74
IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Executive
10b. KIND OF BUSINESS OR INDUSTRY Dept. Store
11. BIRTHPLACE (City and state or country) Ft. Smith, Ark.
12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Aaron Fuller
13b. MOTHER'S MAIDEN NAME Frieda Baer
14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unk. (If yes, give war or dates of
16. SOCIAL SECURITY NO.
17. INFORMANT Address Mrs. J. Glaser-801 S. Skinker Blvd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RENAL FAILURE - UREMIA — INTERVAL BETWEEN ONSET AND DEATH 2 DAYS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) RUPTURED ABDOMINAL AORTIC
DUE TO (c) ANEURYSM. - ARTERIOSCLEROSIS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 451+

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 9/10/63 to 9/13/63 and last saw her/him alive on 9/13/63
Death occurred at 1:30 AM m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) L. C. Middleman MD
22b. ADDRESS 4919 Forest Park Blvd
22c. DATE SIGNED 9/13/63

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE 9/15/63
23c. NAME OF CEMETERY OR CREMATORY Mt. Sinai Cemetery
23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri

24. FUNERAL DIRECTOR ADDRESS Herman Rindskopf, Inc. 5216 Delmar
25. DATE RECD. BY LOCAL REG. SEP 13 1963
26. REGISTRAR'S SIGNATURE Noah Smith M.D.

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed_____

Licensed Embalmer No. 3691

P. O. Address_____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.